RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION
Washington Disease Management Program
Amendment to 1915(b)(4) Waiver

1. Question: Section 1903(a)(1) providers that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Prepaid Ambulatory Health Plans (PAHPs) in the Washington State Disease Management Program retain 100 percent of the payments. Do the PAHPs retain all of the Medicaid capitation payments? Do the Entities participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity or any other intermediary organization? If the PAHPs are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account etc.).

   State Response: Neither of Washington's contracted PAHPs participates in activities such as intergovernmental transfers or certified public expenditure payments.

   Each of the PAHPs is required to participate in funding the disease management program evaluation that is being conducted by the University of Washington as an outside evaluator. Up to $60,000 annually will be returned from the PAHPs to pay for the program evaluation. Each of the two PAHPs will return the funds upon submission of claims for payment by the University of Washington. Returned funds will then be used by the state to pay for the program evaluation.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment for the PAHPs is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payments. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are use, please describe how the state verifies that the expenditures begin certified are eligible fore Federal matching funds in accordance with 42 CFR 433.51(b)>

State Response: The state share of payments for the Disease Management program is from an appropriation by the state legislature. The estimated total expenditures per year for the Disease management program is $10,212,000.00, and the state share is $5,060,000.00..

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to State for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the PAHPs.

   State Response: No supplemental or enhanced payments are made for these services.

4. Are there any actual or potential payments to PAHPs or other providers under this waiver that supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs). If so, how do these arrangements comply with the limits on payments in § 438.6(c)(5) and §438.60 of the regulations? If managed care contracts include mechanisms such as risk corridors, does the state recoup appropriate amounts of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?

   *State Response: There are **no** actual or potential payments to PAHPs or other providers under this waiver that supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c). The Disease Management contracts do not include mechanisms such as risk corridors.*

5. In Section D of the amendment, the State stipulates that capitation rates for the PAHPs comply with 42 CRF 438.6(c). However, to date, CMS has not received the documentation required by 42 CFR 438.6(c)(4), i.e., the actuarial certification of the rates. Please provide the required certification.

   State Response: Please see the attached documents, which include: the October 15, 2003 cover letter addressed to Alice Lind; an Excel Spreadsheet entitled "DM_Appendices"; and Exhibit 1, Capitated Contract Ratesetting – Actuarial Certification.